A PIECE OF MY MIND

Good Documentation

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My great-grandfather was a physician in Europe in the early 20th century. He attended medical school in Vienna, practiced for many years in Prague, and died there long before I was born. I knew little else about him, and most of the family's records and memorabilia had been lost in their frantic emigration to the United States at the beginning of World War I. His daughter, my grandmother, would occasionally tell stories about him coming home with a chicken tucked under his arm that had been given as payment for a house call or recall the morning she found him asleep on the front porch, spattered with blood, after a long night of emergency surgery.

When I eventually told Grandma that I too was interested in medicine, she was thrilled. After rummaging around in her closet, she eagerly produced a small wooden box filled with notecards. Grandma recalled how as a young girl, she would spend nights sitting with her father as he wrote these notes about patients he had seen and shared bits and pieces about the problems they had and how he was helping them. She kept a few notes as mementos.

As we looked at the cards together, I was impressed with his elegant handwriting and the consistent format he used for each patient. The notes looked professional, competent, and although brief, complete. At the bottom of each patient's card was a little addendum that Grandma translated for me: "Lost first wife 10 years ago," "Likes to be called Juri," "Keeps bees," "Deaf in left ear." Every single card had a similarly personal notation. After reading a dozen or so, Grandma couldn't see through her tears and had to stop, saying, "This is how much he cared about his patients."

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As a medical student, intern, and resident in the 1980s, I remember taking great pride in my handwritten notes. I worked hard to make them legible, organized, and on point, and I tried to emphasize my differential diagnosis, thought process, and unanswered questions. Like my great-grandfather, I always tried to include an interesting piece of the patient's personal story. I'm convinced that the small amount of extra time I spent searching for those personal tidbits paid great dividends in terms of patient satisfaction and trust, and I'm also convinced that my first job offer out of residency was in no small part due to the quality of my notes impressing a certain attending physician.

Eventually, it became my turn to be the attending, and to mentor and supervise medical students, residents, and other physicians; eventually, too, came the transition to the electronic health record (EHR). As a middle-aged, keyboard-challenged technophobe with a busy and diverse primary care practice I was dubious about the necessity for change, and learning to efficiently operate the EHR would prove to be a protracted struggle. Nevertheless, I knew that mastering it was critical to continuing my life as an employed physician and medical school instructor, so I worked hard to "get on board." Now, 15 years later, virtually all my patient care documentation, peer review, case consultations, and "teachable moments" revolve around the EHR, and as I approach retirement, I've been reflecting on the merits of that revolution.

When my hospital's chief executive officer first told me that we were transitioning to the EHR in 2003, he echoed the Institute of Medicine's position statement that the EHR would make health care "better, safer, and more efficient." Has it? Many studies have asked this question, targeting end points such as reducing medical errors, shortening the length of stay, reducing mortality, and facilitating preventive care. The findings have been inconsistent. To date the literature can provide neither a ringing endorsement nor a firm repudiation of the EHR's impact on the quality of patient care. As a clinician my conclusions have been very similar. The EHR helps me organize data in meaningful ways, not only to improve the care of individual patients but also to track the effectiveness of my practice as a whole, compare my results to national standards, and even assist in research efforts. I have also found the electronic prescribing functions to be most useful in preventing errors related to allergies, drug interactions, and dosing options. As a family physician, the electronic reminders regarding preventive care milestones have often prompted me to remember the "big picture" during a busy 15-minute visit. Without a doubt, these aspects of the EHR have improved the quality of my care of patients.

Why, then, do I remain so ambivalent about the EHR's place in my life and the lives of my patients? Because repetitively typing EHR notes on my patient interactions is, for me, a soul-sapping exercise in data entry; reviewing the novella-length EHR notes of other clinicians has become a tiring and cynical hunt for meaningful observations, interpretations, or conclusions. This is not the fault of the EHR. The EHR was never designed to facilitate a human narrative, which was what my great-grandfather's documentation was all about. Like him, when I wrote my notes, I was forced

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to think about how best to describe my patient's idiosyncrasies, heart sounds, or skin lesions. It forced me to think about how best to state my conclusions and concerns, and how best to justify my plan of action. In the writing of these things, I learned them, remembered them, and they became important to me. Now, with a single click, I can populate an entire physical examination, add reams of diagnostic tests, or even generate a complete, comprehensive note. I can click to add impressive phrases such as: "Extensive differential diagnosis generated and considered," "Laboratory and radiology results reviewed," or "Diagnosis and care plan discussed at length with patient and all questions answered." From a time-management standpoint, this is miraculous, and I use these tools to survive every day, but at what cost?

By its very nature, the EHR can offer no guarantees that I performed the examination that is so thoroughly documented, that I reviewed the pages of diagnostics pasted in, or that I actually took the time to have a discussion with the patient. It can be easy, and tempting, to pad an electronic note with everything "on the menu" to make it look impressively thorough or to justify an "upcoded" billing level. I see this with physicians-in-training who approach EHR documentation with the "more is better" method. More is not better.

A good note should offer insights into the thought processes, intuitions, and recommendations of the clinician. It should provide an assessment of the myriad psychosocial factors that may affect each patient's care. It should be an honest and accurate reflection of both the clinician's thoughts and the patient's condition. Although voice recognition technology offers much promise, most current EHR platforms make it very difficult to efficiently achieve these goals. We click on the buttons that we have been told to click and hope it all somehow fits together. Sometimes, at the end of a long day when I have finally finished pointing, clicking, and pasting together my last note, I know in my heart that some of my documentation falls short of what my patients truly deserve.

Tomorrow, or 80 years from now, will someone be able to read through a bundle of my EHR-generated notes and develop any meaningful insights into how I cared for my patients or who those patients were? Will they sense any of the human aspect of patient care? Will they be able to discern what was truly important? What was real? The EHR may well prove to be "safer" and "more efficient," but until it can more easily allow us to choose our own words, set our own priorities, and craft notes that better assist patients and colleagues, I doubt that my great-grandfather would say that it is "better."

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